STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 76-23591

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	BRYAN	JONATHAN	CANAPP	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH DAY YEAR	9-4-19 76	2b. HOUR	M
3. SEX	male	4. RACE	white	5. DATE OF BIRTH MONTH DAY YEAR	May 14, 1958	6. AGE (IN YEARS LAST BIRTHDAY)	18 YRS.
IF UNDER 1 YR. MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR	9-4-19 76	2d. HOUR	1:30 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH	Worcester County MD.
10. CITY OR TOWN OF DEATH	Ocean City	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	2606 Philadelphia Ave.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Salesman	12b. KIND OF BUSINESS OR INDUSTRY	Hardware

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Baltimore	Baltimore	YES ☒ NO ☐	408 Dale Ave.

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Earl L. Canapp, Sr.	Edna Josephine Most

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		217-76-6434	Earl L. Canapp, Sr.	Same as #13 E

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute carbon monoxide intoxication

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	11 AM 9-4-19 76	Inhaled exhaust fumes from car.

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☒	car	Ocean City / Worcester / Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Ann Dixon TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 9-5-76

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	9/8/1976	Gardens of Faith	Baltimore / Balt. / Md.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Wm. Cook-Brooks Towson, Inc.	1050 York Road Towson, Md. 21204	SEP 8 1976	Tiffany McCready

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RELEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

76-23592

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

1. DECEASED-NAME (Type or print) First / Middle / Last	Frank B. Carmean	2a. DATE OF DEATH Month / Day / Year	Sept 24, 1976
		2b. HOUR	10:30 P.M.
3. SEX	Male	4. RACE	White
5. DATE OF BIRTH	April 12, 1895	6. AGE (In years last birthday)	81 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. COUNTY OF DEATH	Worcester Md.
10. CITY OR TOWN OF DEATH	Snow Hill	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	211 S. Washington St
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Retired Barber	12b. KIND OF BUSINESS OR INDUSTRY	Barber
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Worcester
13c. CITY OR TOWN	Snow Hill	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	
13e. STREET AND NUMBER	211 S. Washington St.		
14. FATHER'S NAME First / Middle / Last	Bruce E. Carmean	15. MOTHER'S MAIDEN NAME First / Middle / Last	Mary H. Hales
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	Yes	(If yes give war or dates of service)	WWI
16b. SOCIAL SECURITY NO.	213017563	17. INFORMANT Address	Edith B. Carmean, Snow Hill, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INANITION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SEVERAL DAYS
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CARCINOMA OF PALATE — SEVERAL MONTHS
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
ARTERIO-SCLEROTIC HEART DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (~~this hospital~~) attended the deceased from Jan, 19 74, to Sept, 19 76, that (I) (~~saw~~) last saw the deceased alive on 9-23 19 76, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	Dorothy C. Holzworth M.D.	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐
22c. DATE SIGNED	9-27-76				
22d. PHYSICIAN'S NAME (Type)	DOROTHY C. HOLZWORTH	22e. ADDRESS	104 Bay St. Snow Hill, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY ~~OR CREMATORY~~	23d. LOCATION (City or Town)	(County) (State)
Burial	9-27-76	Whitecoat Meth	Snow Hill	Md.
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
Norman F. Warren	Snow Hill, Md.	SEP 29 1976	Audrey McCready	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR

REG. NO. 76-23593

1. DECEASED NAME (TYPE OR PRINT) — FIRST: BRUCE — MIDDLE: J. — LAST: EDMONSTON

2a. DATE OF DEATH — KNOWN [X] ESTIMATED [ ] — MONTH: 9 — DAY: 9 — YEAR: 1976

2b. HOUR: 11:00 AM

3. SEX: M

4. RACE: W

5. DATE OF BIRTH — MONTH: 12 — DAY: 31 — YEAR: 18

6. AGE (IN YEARS LAST BIRTHDAY): 57 YRS. — IF UNDER 1 YR. MONTHS: — DAYS: — IF UNDER 24 HRS. HOURS: — MIN:

2c. DATE PRONOUNCED DEAD — MONTH: 9 — DAY: 9 — YEAR: 1976

2d. HOUR: 11:00 AM

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: WORCESTER MD.

10. CITY OR TOWN OF DEATH: OCEAN City

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 10th + Philadelphia Ave

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SUPERVISOR

12b. KIND OF BUSINESS OR INDUSTRY: INSURANCE

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD.

13b. COUNTY:

13c. CITY OR TOWN: BALTIMORE

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: 1307 LAKESIDE AVE

14. FATHER'S NAME — FIRST: Charles — MIDDLE: H. — LAST: EDMONSTON

15. MOTHER'S MAIDEN NAME — FIRST: Helen — MIDDLE: — LAST: PORTER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WW2

16b. SOCIAL SECURITY NO.: 218-01-2556

17. INFORMANT — ADDRESS: Helen P. EDMONSTON

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ACUTE Myocardial INFARCTION

DUE TO, OR AS A CONSEQUENCE OF

(b): ASVD

DUE TO, OR AS A CONSEQUENCE OF

(c):

4109

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [ ] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Thomas L. Jones MD — TITLE (SPECIFY) M.D. Deputy — MEDICAL EXAMINER — DATE SIGNED 9/9/76

EXAMINER'S NAME (TYPE OR PRINT): Thomas L. Jones MD — ADDRESS: 2606 Philadelphia Ave

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION

23b. DATE: 9/13/76

23c. NAME OF CEMETERY OR CREMATORY: GREEN MOUNT

23d. LOCATION CITY OR TOWN: BALTIMORE COUNTY: STATE: Md

24. FUNERAL DIRECTOR NAME: Mitchell-Miedefeldt Home ADDRESS: 6500 York Rd

25a. DATE REC'D. BY REGISTRAR: SEP 14 1976

25b. REGISTRAR'S SIGNATURE: Pritzy McCready

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR 48 HOURS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 76-23594

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RELEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Ruby	MIDDLE: Williams	LAST: Hummer	2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐	MONTH: 9	DAY: 4	YEAR: 1976	2b. HOUR: 7:45 PM
3. SEX: Female	4. RACE: Cauc.	5. DATE OF BIRTH: MONTH April DAY 30 YEAR 1900	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.	IF UNDER 1 YR.: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: MONTH 9 DAY 4 YEAR 1976		2d. HOUR: 7:45 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: WORCESTER MD.					
10. CITY OR TOWN OF DEATH: Ocean City	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 26 Street Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Buyer	12b. KIND OF BUSINESS OR INDUSTRY: Retail					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Virginia	13b. COUNTY: Arlington	13c. CITY OR TOWN:	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 1938 Columbia Pike				
14. FATHER'S NAME: FIRST Seymour	MIDDLE	LAST Williams	15. MOTHER'S MAIDEN NAME: FIRST Cora	MIDDLE	LAST Summers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 577-07-0158	17. INFORMANT: Miss Tracy Williams	ADDRESS: 1301 S. Scott St. Arl., Va. 22204				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Myocardial Infarction	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4109	DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease	
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Thomas H. Jones M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 9/4/76

EXAMINER'S NAME (TYPE OR PRINT): _____ ADDRESS: _____

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Sept. 8, 76	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN: Suitland COUNTY: Prince Georges STATE: Md.
24. FUNERAL DIRECTOR NAME: Arlington Funeral Home	ADDRESS: 3901 N. Fairfax Dr. Arl., Va. 22203	25a. DATE REC'D. BY REGISTRAR: SEP 9 1976	25b. REGISTRAR'S SIGNATURE: Jeffrey McCready

DHMH - 17
(VR A15 ME (5))
30M 7/73

#5,FilmG500 10/4/76 kam

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

76-23595

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print): First: William; Middle: C; Lost: KNOPF
2a. DATE KNOWN OF DEATH ESTIMATED ☐: Month 9, Doy 14, Yeor 1976
2b. HOUR: 9:44 M
3. SEX: M
4. RACE: W
5. DATE OF BIRTH: 5-23-29
6. AGE (In years last birthday): 47 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.
2c. DATE PRONOUNCED DEAD: Month 9, Doy 18, Yeor 1976
2d. HOUR: 10:15 M
7a. BIRTHPLACE (State or foreign country): WASH. DC
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: WORCESTER Md.
10. CITY OR TOWN OF DEATH: Ocean City
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 2606 Philadelphia Ave
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): STORE
12b. KIND OF BUSINESS OR INDUSTRY: RETAIL
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD
13b. COUNTY: WORCESTER
13c. CITY OR TOWN: Ocean City
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 75th - Tiena #2
14. FATHER'S NAME: First WILLIAM; Middle J.; Lost KNOPF
15. MOTHER'S MAIDEN NAME: First AGNES; Middle MARY; Lost BRADLEY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 577-32-8784
17. INFORMANT: William Abert ADDRESS: Ocean City, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost.
4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** thot I took charge of the remains described above, held an Autapsy ☐, Inspection ☒, Inquiry ☒, and in my opinion deoth resulted from: Notural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Thomas Jones MD M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(Street, city, town, or county) 2606 Phil. Ave. Ocean City Md
22b. DATE SIGNED: 9/14/76

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 9-18-76
23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN
23d. LOCATION (City or Town) (County) (Stote): WASH. D.C.

24. FUNERAL DIRECTOR: ULRICH FUNERAL HOME ADDRESS: Berlin Md
25a. REC'D BY REGISTRAR (DATE): SEP 23 1976
25b. REGISTRAR'S SIGNATURE: Brittany McCready

DHMH-17 1/71 10M
(VR A15ME (5))

Item 11 g500 10/8/76 gj

1
FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

76-23596

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month	Day	Year	2b. HOUR
Vincent	Robert	Lewis	9	1	1976	11:40 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month / Day / Year	2d. HOUR
M	W	Mar 28, 1903	68 YRS.			9 / 2 / 1976	12:15 A.M.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH				
MARYLAND	USA		Worcester Md.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY				
Ocean City	26th St Medical Center	MOWER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER			
MARYLAND	Wor.	Ocean City		405 Phila. Ave			
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last		
KING	LEWIS		OCEA		Collins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
NO	NO	221-07-9732	MR. R. B. LEWIS	Ocean City md			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Myocardial Infarction	
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic Cardiovascular Disease	
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Thomas L. Jones M.D. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED 9/24/76

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR ~~CREMATORY~~	23d. LOCATION (City or Town)	(County)	(State)
BURIAL	9/4/76	EVERGREEN	BERLIN	WOR	MD

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Anna A. Burbage	Berlin Md.	SEP 27 1976	Tiffany McCready

DHMH-17 1/77-10M
(VR A15ME (8))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

76-23597

1

1. DECEASED-NAME (Type or print) First: MADELINE DECAMP ALLEN Middle: MARRINER Last:
2a. DATE OF DEATH Month: SEPT Day: 28 Year: 1976
2b. HOUR: after 12 M
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: JULY 30, 1901
6. AGE (In years lost birthday): 75 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): VIRGINIA
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: WORCESTER Md.
10. CITY OR TOWN OF DEATH: STOCKTON
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): RESIDENCE
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): SEAM STRESS
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: WORCESTER
13c. CITY OR TOWN: STOCKTON
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: BOX 37 STOCKTON ROAD
14. FATHER'S NAME First: EDWARD Middle: THOMAS Last: ALLEN
15. MOTHER'S MAIDEN NAME First: EVA Middle: Last: LILLISTON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
16b. SOCIAL SECURITY NO. (If yes give war or dates of service): ~~212-74-7619~~
17. INFORMANT: NELDA MADDOX Address: 206 LINDEN AVE. POCOMOKE, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 Min.
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary Artery Disease — 1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c): Arteriosclerotic Heart Disease — Years
4100
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): 4. Hypertension 1. Recent Congestive Failure 2. Old Myocardial Infarct 3. Diabetes Mellitus

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH [ ] OR CONTRIBUTING [ ]
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (~~this hospital~~) attended the deceased from May 5, 1961, to Sept. 25, 1976, that (I) (~~we~~) last saw the deceased alive on Sept. 26, 1976, and that in (my) (~~our~~) opinian death occurred at the date and haur and from the causes stated abave, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Charles W. Trader M.D. DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: Sept. 28, 1976.
22d. PHYSICIAN'S NAME: Charles W. Trader, M.D.
22e. ADDRESS: 302 Market St/, Pocomoke City, Md. 21851

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: SEPT 30, 1976
23c. NAME OF CEMETERY OR CREMATORY: NELSON CEMETERY
23d. LOCATION (City or Town) (County) (State): POCOMOKE WORCESTER MD
24. FUNERAL DIRECTOR: Scott S. Nelson
ADDRESS: POCOMOKE CITY, MD
25a. REC'D BY REGISTRAR DATE: OCT 4 1976
25b. REGISTRAR'S SIGNATURE: Tiffany McCready

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

76-23598

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: PAUL	Middle: BERNARD	Last: MOYER	2a. DATE KNOWN OF DEATH ESTIMATED ☐	Month: 9	Day: 18	Year: 1976	2b. HOUR: 3:25 P M
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: 2/18/22	6. AGE (in years last birthday): 54 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month 9	Day 18	Year 1976	2d. HOUR: 3:25 P M
7a. BIRTHPLACE (State or foreign country): PA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: WORCESTER Md.						
10. CITY OR TOWN OF DEATH: OCEAN City	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 2606 Philadelphia Ave	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY: MINE WORKER						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PA	13b. COUNTY: CAMBRIA	13c. CITY OR TOWN: JOHNSTOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: COLLEGE PARK #108					
14. FATHER'S NAME	First: JOHN	Middle	Last: MOYER	15. MOTHER'S MAIDEN NAME	First: JOSEPHINE	Middle	Last: CHIRDON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES	(If yes give war or dates of service): WWII	16b. SOCIAL SECURITY NO.: 176-16-1577	17. INFORMANT: GARY MOYER	ADDRESS: SOLOMON, MO.					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b): [redacted]
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: B. Parek M.D.
EXAMINER'S NAME (Type): B. Parek MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county): 2606 Phil. Ave - Ocean City Md.
22b. DATE SIGNED: 9/18/76

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	9/22/76	FOREST LAWN	CAMBRIA CO., PA.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ULLRICH FUNERAL HOME	BERLIN, MD.	SEP 23 1976	Tiffany McCready

FOR: FORMER F.H.

OHMH-17 1/71 10M
(VR A15ME (5))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

76-23599

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the death certificote be executed within 24 hours after death. Poge 4 may be retoined by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physicion and completely filled in by the funerol director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after deoth.

1. DECEASED-NAME (Type or print) First / Middle / Last	Clarence N. Pilchard	2a. DATE OF DEATH Month Day Year	Sept. 22, 1976	2b. HOUR	2A M
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH	May 18, 1914
6. AGE (In years last birthday)	62 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH Worcester Md.
10. CITY OR TOWN OF DEATH	Girdletree	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Main St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Waterman
12b. KIND OF BUSINESS OR INDUSTRY	Seafood				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Worcester	13c. CITY OR TOWN	Girdletree
13d. INSIDE CITY LIMITS?	YES ☑ NO ☐	13e. STREET AND NUMBER	Main St. (No Number)		
14. FATHER'S NAME First / Middle / Last	Clarence Pilchard	15. MOTHER'S MAIDEN NAME First / Middle / Lost	Lavenia Pilchard		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	No	(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	214 30 8550
17. INFORMANT Address	Delmarva T. Pilchard, Girdletree Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	MYOCARDIAL INFARCT	MINUTES
DUE TO, OR AS A CONSEQUENCE OF (b)	HYPERTENSIVE CARDIOVASCULAR DISEASE	10 YRS
DUE TO, OR AS A CONSEQUENCE OF (c)		

H-100

Conditians, if any, which gave rise to immediote couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
ALCOHOLISM SEVERE ARTHRITIS BOTH KNEES

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this haspital) attended the deceased from APRIL, 1945, to SEPT, 1976, thot (I) (~~we~~) last saw the deceased olive on SEPT 3, 1976, and thot in (my) (~~our~~) apinion deoth occurred on the date and hour ond from the couses stoted obave, (I) (~~we~~) (~~did~~) (did not) view the body ofter deoth.

22b. SIGNATURE	Robert La Mar	MD DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐
22c. DATE SIGNED	9-24-76				
22d. PHYSICIAN'S NAME (Type)	ROBERT C. LA MAR, M.D.	22e. ADDRESS	104 Bay St, Snow Hill, Md. 21863		

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	9-24-76	23c. NAME OF CEMETERY ~~OR CREMATORY~~	Baptist
23d. LOCATION (City or Town) (County) (State)	Girdletree, Maryland				
24. FUNERAL DIRECTOR	Truman T. Dennis, Snow Hill Md.	ADDRESS		25a. REC'D BY REGISTRAR DATE	SEP 27 1976
25b. REGISTRAR'S SIGNATURE	Tiffany McCready				

VR A15 (4)
25m-1/70

#6, FilmG500 10/4/76 kam

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 76-23600

1. DECEASED NAME (TYPE OR PRINT) — FIRST: JOSEPH; MIDDLE: NMI; LAST: RENGEL

2a. DATE OF DEATH — KNOWN ☑ / ESTIMATED ☐: MONTH 9, DAY 14, YEAR 76

2b. HOUR: 2:45 P.M.

3. SEX: M

4. RACE: W

5. DATE OF BIRTH: MONTH 8, DAY 24, YEAR 16

6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS.

IF UNDER 1 YR.: MONTHS; DAYS

IF UNDER 24 HRS.: HOURS; MIN

2c. DATE PRONOUNCED DEAD: MONTH 9, DAY 14, YEAR 76

2d. HOUR: 2:45 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA.

7b. CITIZEN OF WHAT COUNTRY?: USA.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑

9. BALTIMORE CITY OR COUNTY OF DEATH: WORCESTER MD.

10. CITY OR TOWN OF DEATH: BERLIN

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): RT. 50

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOME IMPR.

12b. KIND OF BUSINESS OR INDUSTRY: BLDG.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MD

13b. COUNTY: WOR

13c. CITY OR TOWN: BERLIN

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: LAKE NAVEN

14. FATHER'S NAME — FIRST: UNKNOWN; MIDDLE; LAST

15. MOTHER'S MAIDEN NAME — FIRST: UNKNOWN; MIDDLE; LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES

(IF YES, GIVE WAR OR DATES): 1934-1937

16b. SOCIAL SECURITY NO.: 219-05-1891

17. INFORMANT — ADDRESS: VILMA KENDALL BALTO. MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of Colon with Metastasis

1538

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Thomas L. Jones M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER

DATE SIGNED: 9/15/76

EXAMINER'S NAME (TYPE OR PRINT): _____ ADDRESS: _____

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 9-17-76

23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEM. PK.

23d. LOCATION — CITY OR TOWN: BERLIN; COUNTY: WOR.; STATE: MD.

24. FUNERAL DIRECTOR — NAME & ADDRESS: ULRICH FUNERAL HOME BERLIN MD

25a. DATE REC'D. BY REGISTRAR: SEP 23 1976

25b. REGISTRAR'S SIGNATURE: Tiffany McCready

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, NOTIFY PHYSICIAN OR MEDICAL EXAMINER. EXECUTE THE CERTIFICATE. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR RECORDS.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 76-23601

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): CLARENCE H. TAYLOR
2a. DATE OF DEATH: Sept. 2 1976
2b. HOUR:
3. SEX: M
4. RACE: Negro
5. DATE OF BIRTH: June 19 1900
6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Stockton
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Worcester MD.
10. CITY OR TOWN OF DEATH: Girdletree
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): RT #1 BOX 27A
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer
12b. KIND OF BUSINESS OR INDUSTRY: Forestry

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: md
13b. COUNTY: Worcester
13c. CITY OR TOWN: Girdletree
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: RT #1 Box 27A

14. FATHER'S NAME: DALLAS Taylor
15. MOTHER'S MAIDEN NAME: MARY COLLICK
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO.
16b. SOCIAL SECURITY NO.: 220-32-0744
17. INFORMANT ADDRESS: DALLAS H. Taylor (SAME AS Above)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis 2° to ASHD — Minutes
DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD — Years
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Past CVA (x2-3) Severe COPD Past CHF

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 12 Apr 76, 19 76, to 12 Aug, 19 76, that (I) (we) last saw the deceased alive on 12 Aug 76, 19 76, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: E J Colwell
DEGREE: MD
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED: 7 Sept 76
22d. PHYSICIAN'S NAME (TYPE OR PRINT): E J Colwell
22e. ADDRESS: PGH Salisbury MD 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL
23b. DATE: 9-6-76
23c. NAME OF CEMETERY OR CREMATORY: Coolspring Unit
23d. LOCATION CITY OR TOWN / COUNTY / STATE: Girdletree-Worc. Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Jolley Mem. Chapel Salis. Md.
25a. DATE RECD. BY REGISTRAR: SEP 8 1976
25b. REGISTRAR'S SIGNATURE: [illegible]

DHMH-16 60M 1/73
(VR A 15 (4))

76-23801

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

76-23602

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Part 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: EDWARD	Middle: (WMN)	Last: VERNON	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐	Month: 9	Day: 1	Year: 1976	2b. HOUR: 12:23 M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 4/9/22	6. AGE (In years last birthday): 54 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month 9 Day 7 Year 1976	2d. HOUR: 1:17 P M	
7a. BIRTHPLACE (State or foreign country): PENNA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: WORCESTER Md.					
10. CITY OR TOWN OF DEATH: OCEAN City	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): U.S. POSTAL SERVICE	12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: TAKOMA PARK	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 7810 GARLAND AVE.				
14. FATHER'S NAME: First WILLIAM Middle Last VERNON	15. MOTHER'S MAIDEN NAME: First ROSE Middle Last DAVIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WW II	16b. SOCIAL SECURITY NO.: 193-22-6283	17. INFORMANT: MRS. LORETTA I. VERNON	ADDRESS: (SAME AS #13 ABOVE)					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b): ACVD
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Thomas L. Jones, MD M.D.
EXAMINER'S NAME (Type): Thomas L. Jones MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county)
22b. DATE SIGNED: 9/1/76

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept 3-1976	George Washington	Riggs Rd & Geo. Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Walter Walters	Takoma Funeral Home 257 Carroll Ave.	DATE SEP 7 1976	Tiffany McCready

DHMH-17 1/71 10M
(VR A15ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 76-23603

1. DECEASED NAME (TYPE OR PRINT) — FIRST: MYRTLE; MIDDLE: JONES; LAST: WARREN

2a. DATE OF DEATH — KNOWN ☒ ESTIMATED ☐ — MONTH: 9; DAY: 15; YEAR: 1976

2b. HOUR: 12 30 P M

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH — MONTH: AUG; DAY: 21; YEAR: 1921

6. AGE (IN YEARS LAST BIRTHDAY): 55 YRS.

IF UNDER 1 YR. — MONTHS: ; DAYS: ; IF UNDER 24 HRS. — HOURS: ; MIN.:

2c. DATE PRONOUNCED DEAD — MONTH: 9; DAY: 15; YEAR: 1976

2d. HOUR: 1 30 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: WORCESTER MD.

10. CITY OR TOWN OF DEATH: BERLIN

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): OWN HOME AT

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: WOR.

13c. CITY OR TOWN: BERLIN

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS: R.D. Parker Town

14. FATHER'S NAME — FIRST: HARRY E.; MIDDLE: ; LAST: JONES

15. MOTHER'S MAIDEN NAME — FIRST: DELIA; MIDDLE: ; LAST: CROPPER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO

16b. (IF YES, GIVE WAR OR DATES): NO

16b. SOCIAL SECURITY NO.: 213-14-2346

17. INFORMANT — ADDRESS: MR. GEORGE WARREN BERLIN R.T. MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infarction

4109

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2):

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.):

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE: Thomas Jones M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 9/15/76

EXAMINER'S NAME (TYPE OR PRINT): THOMAS G. JONES, M.D. ADDRESS: 2606 PHILA AVE, OCEAN CITY, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 9/18/76

23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL

23d. LOCATION CITY OR TOWN: BERLIN COUNTY: WOR STATE: MD

24. FUNERAL DIRECTOR NAME AND ADDRESS: Anna A. Burbage Berlin Md

25a. DATE REC'D. BY REGISTRAR: SEP 24 1976

25b. REGISTRAR'S SIGNATURE: Anthony McCreary

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH IN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

1

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

76-23604

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File, pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

DHMH-17 1/71 10M
(VR A15ME (5))

1. DECEASED-NAME (Type or Print)	First: CECIL	Middle: J.	Last: WEATHERHOLT	2a. DATE KNOWN OF DEATH ESTIMATED ☐	Month: 9	Day: 5	Year: 1976	2b. HOUR: 1:15 M		
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: 2/25/28	6. AGE (In years last birthday): 48 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month 9	Day 5	Year 1976	2d. HOUR: 1:15 M	
7a. BIRTHPLACE (State or foreign country): INDIANA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: WORCESTER Md.							
10. CITY OR TOWN OF DEATH: OCEAN City	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 2000 PHILA AVE	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): FOREMAN	12b. KIND OF BUSINESS OR INDUSTRY: ROADS							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. VIRG.	13b. COUNTY: HAMPSHIRE	13c. CITY OR TOWN: ROMNEY	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 372 WEST HIGH ST.						
14. FATHER'S NAME: First CECIL	Middle	Last WEATHERHOLT	15. MOTHER'S MAIDEN NAME: First MAY	Middle	Last Pohelelien					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): WWII	16b. SOCIAL SECURITY NO.: 513-26-0887	17. INFORMANT: ARLENE WEATHERHOLT	ADDRESS: SAME (WIFE)							

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): JON GRAHAM (THOMAS L. JONES MD) M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED: 9/5/76

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 9-9-76	23c. NAME OF CEMETERY OR CREMATORY: INDIAN MOUND CEM.	23d. LOCATION (City or Town): ROMNEY,	(County):	(State): W. VA.
24. FUNERAL DIRECTOR: ULRICH FUNERAL HOME	ADDRESS: BERLIN MD	25a. REC'D BY REGISTRAR DATE: SEP 14 1976	25b. REGISTRAR'S SIGNATURE: Pinkney McCready		

FOR: MCKEE F.H. AUGUSTA, W.VA.